SEE REVERSE FOR INSTRUCTIONS

Illinois Department of Healthcare and Family Services

NURSING ASSISTANT TRAINING AND COMPETENCY EVALUATION REIMBURSEMENT REQUEST

1. Provider No.: _____ (12 Digits) 2. Provider Name: _____ 3. Phone No.: (____)_____

4. Provider Address: _____ (Street) (City) (State) (Zip Code) 5. Provider Geo. Area: _____

6. Course Certification No.:_____ 7. College Dist. No.:_____ 8. IDPH Lic. Bed Cap.: _____ 9. Total Occupancy: _____ 10. No. of IDPA Res.: _____

11. Nursing Assistant's Social Security No.	12. Nursing Assistant's Name (Last, First, MI)	13. Comp. Eval. Fee	14. TRAINING Begin Date MM/DD/YY	End Date MM/DD/YY	15. Hourly Salary	16. Total Hours of Training	17. Total Training Salary	18. Tuition Charges	19. Instr. Mat. Costs	20. Total Training Amount
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21. Total Evaluation Fee Requested:

22. FOR AGENCY USE ONLY: Evaluation Fee Payment:

23. Total Training Amount Requested:

24. FOR AGENCY USE ONLY:Training Payment:

25. FOR AGENCY USE ONLY: (Total Payment Evaluation and/or Training):

I certify that all entries on this claim are true, accurate and complete. I agree to keep and make available to State and Federal officials such records as are necessary to establish compliance with Department regulations and to support this claim. I understand that payment will be made from State and Federal funds and that any false claims, statements or documents or concealment of material facts may be cause for prosecution or other appropriate legal action. I further certify that the facility, in compliance with the Civil Rights Act of 1964, and the Rehabilitation Act of 1973, has not discriminated on the grounds of race, color, religion, sex, national origin or handicap.

26. Authorized Signature: _____ 27. Date: _____

INSTRUCTIONS FOR COMPLETION
(Please Type or Print)

1. Enter facility's Federal Employers Identification Number (nine digits), plus the last three digits assigned by the Department for billing purposes.
2. Enter the facility's name.
3. Enter the facility's telephone number, including the area code.
4. Enter the facility's address.
5. Enter the facility's Geographic Area.
6. Enter the course certification number assigned by the Illinois Department of Public Health.
7. Enter the college district number in which the tuition charge has been based.
8. Enter the facility's total bed capacity licensed by the Illinois Department of Public Health.
9. Enter the total number of residents currently in the facility.
10. Enter the number of Medicaid residents currently in the facility on the day the facility completes Form HFS 2310.
11. Enter the nursing assistant's Social Security Number.
12. Enter the nursing assistant's full name, using the last name, first name, middle initial format.
13. Enter the competency evaluation fee.
14. Enter the date the training began and ended using the MM/DD/YY format.
15. Enter the hourly salary, including fringe benefits, paid to the trainee by the facility during the training program. The amount listed should be the actual salary paid, but shall not exceed the Department's salary and benefit table. If the facility does not pay the trainee a salary while involved in training, a "O" must be entered.
16. Enter the total number of classroom and clinical training hours.
17. Enter the total amount of salary, including fringe benefits, paid to the trainee, in accordance with the total number of hours of training only if the trainee was paid her hourly salary during the training program. If the trainee was not paid a salary during training enter "O".
18. Enter the tuition cost up to the tuition for the recognized educational institution in the HSA, in accordance with the Department's tuition table.
19. Enter the cost of instructional materials up to the Department's maximum allowable rate.
20. Enter the total amount requested for the trainee's salary, tuition and instructional materials.
21. Enter the total requested for competency evaluation reimbursement.
22. This area is "FOR AGENCY USE ONLY".
23. Enter the total amount requested for training reimbursement.
24. This area is "FOR AGENCY USE ONLY".
25. This area is "FOR AGENCY USE ONLY".
26. After reading the certification statement, the administrator or authorized representative of the facility must sign and date the billing form. Stamped signatures are not acceptable. Only legally authorized representatives of the facility may sign this form, and only original signatures are acceptable.